Comments on the 1115 Waiver Application Draft Posted January 7, 2014
Prepared by McDermott Center (dba Haymarket Center)

Following are comments from Haymarket Center regarding the 1/7/2014 1115 Waiver Application Draft.

General / Definitions

One of the waiver's stated goals is "Enhance access to community-based behavioral health and substance abuse services and encourage integration of these services with physical health care services." Yet the term "substance abuse" or "substance use" is mentioned just eight times in the 78 page document. Comments on the 1115 waiver concept paper from very prominent voices in the substance use disorders treatment field, including the Illinois Alcoholism and Drug Dependence Association (IADDA) and the law firm Popovits and Robinson, were virtually ignored in the draft application. The document needs to show a much clearer understanding of substance use disorders as distinct from mental health disorders, and how substance use disorders services fit into the service system in Illinois.

In one example, on page 14, "… implement a population screening measure that allows better identification of patients with mild to moderate depression and related behavioral health disorders (anxiety, grief, substance use)," substance use is treated as a behavioral health disorder that is a sub-set of depression. In another passage, on page 17, substance abuse is treated as separate from behavioral health: "…drive integration of services across the full continuum (including behavioral health, substance abuse and long-term care)."

The terms need a clear definition that is used consistently. "Substance use disorders" should be mentioned *every time* alongside "behavioral health disorders."

Pathway 1: Transform the Health Care Delivery System

We recommend the second bullet at the bottom of page 14 be revised as follows:

> Metrics would include screening levels, number of patients identified with mental health **and/or substance use** conditions treatable in the community health setting, co-morbidity profiles, number of patients enrolled in care by payer class and type of intervention, number remaining involved in care coordination.

We recommend the bullet at the bottom of page 17 be revised as follows:

> Demonstrated movement toward an Integrated Delivery System by: 1) participation in an ACE, or 2) contractual arrangements **between** primary care and behavioral health **and substance use** providers caring for Medicaid patients.

Measures of health system integration on pages 17 and 18 should include the following measure:

- Rate of follow-up appointments kept with substance use disorders provider within 7 days for patients hospitalized with substance abuse conditions.

Pathway 3: 21st Century Health Care Workforce

Illinois rules allow for substance use disorder services to be delivered by certified alcohol and drug counselors (CADCs) certified by the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA). Please consider including certified alcohol and drug counselors in the loan repayment program.

Pathway 4: LTSS Infrastructure, Choice, and Coordination

Is this the best place in the waiver for inclusion of substance abuse services? The majority of substance use disordered clients are not LTSS clients, and we don't believe the State means to exclude the bulk of substance use needs from coverage in the waiver.

The paragraph "Timely Access and Identification of Behavioral Health Needs" on page 40 could benefit from more clarity. For example, the following sentence appears to mix several different populations and service types in an undifferentiated way:

> Therefore Illinois proposes to implement a series of prevention and early intervention programs that include Screening, Brief Intervention, and Treatment (SBIRT) along with the target efforts within the program already in existence, as well including access to LTSS that prevent or limit residential placements for children with behavioral health needs.

What are the "target efforts within the program already in existence"? SBIRT and LTSS are at opposite ends of a service spectrum and suggest very different target populations. Two sentences later, the following sentence is equally unclear:

> For those who did not benefit from the newly progressive and preemptive approach, we will reinvest savings to support enhanced skills training and Assistance, peer support services, and assistance with non-medical needs associated with long term disability and soon to be eliminated learned dependency on institutional settings.

The first part of the sentence appears to refer to a prevention/early intervention population, but the reference to "long term disability" and "learned dependency on institutional settings" seems to refer to an SMI population. Other elements of the sentence such as enhanced skills training

and Assistance, peer support services, and assistance with non-medical needs should be applied to the substance use population.

The waiver draft says "Illinois will incentivize Medicaid health plans to invest in housing and housing supports for their patients…" on page 41. However, in the webinar conducted Friday, January 10, the question was posed as to whether the waiver would include room and board payments for residential treatment, and the response was basically "no." As IADDA's comments on the 1115 concept paper stated, "A 2004 NIH study conducted in Illinois demonstrated that ASAM Level 3.5 residential treatment, while initially costing more than intensive outpatient or outpatient treatment, had the greatest return on investment and produced the most long-term savings (*Dennis, M. and Scott, L., NIH – NIDA Grant No. R37 DA011323 [2004]).*" Further, the Culhane paper cited on page 41 of the waiver draft cites a study that showed "improved housing outcomes for a group of dually diagnosed [mental health and substance abuse] homeless persons who were provided residential treatment, compared with a control group given standard treatment." For **consistency**, and to improve housing outcomes, the State should also incentivize Medicaid health plans to invest in domiciliary costs in residential treatment as well as in housing.

We applaud the State for acknowledging rate disparities. The substance use disorders treatment field has not had cost of doing business adjustments nor any other rate adjustments in a decade, unlike some other human services, and operates with some of the lowest rates of any of the human services.

Regarding IMD

This is one of the two or three most important issues for the substance use disorders treatment field in Illinois. The IMD exclusion poses a significant limitation for persons requiring

American Society of Addictions Medicine (ASAM) Level III.5 residential care for substance use disorders. This exclusion of a clinically defined level of care will seriously, negatively impact recovery, drive up costs in criminal justice and child welfare systems—and *especially* in hospital emergency departments. Costs to the Medicaid long term will be dramatically increased if persons are denied this critical level of care, as has been demonstrated through federally funded research: a 2004 NIH study conducted in Illinois demonstrated that ASAM Level III.5 residential treatment, while initially costing more than intensive outpatient or outpatient treatment, had the greatest return on investment and produced the most long-term savings *(Dennis, M. and Scott, L,. NIH-NIDA Grant No. R37 DA011323 [2004])*. If the IMD exclusion is not addressed, access to residential treatment will be severely limited, as many inpatient substance use disorder treatment facilities cannot meet the IMD criteria requiring fewer than 16 beds. This diminished access to care will achieve *the opposite* of one of the primary goals of the ACA, being the expansion of access. Individuals with severe addictions may be forced to seek treatment in a much higher cost hospital setting. In addition, as Popovits and Robinson—the law firm with the greatest experience in substance use disorders-related parity issues in Illinois—stated in their waiver concept comments,

> **the IMD exclusion presents a parity issue** since for no other health conditions are Medicaid services provided in certain institutions excluded from coverage. Therefore, we recommend that the State seek a waiver of the IMD exclusion within the consolidated 1115 Waiver proposal. (Emphasis added.)

Application draft pages 39-40 describe development of Specialized Mental Health Rehabilitation Facilities (SMHRFs), to be treated as costs not otherwise matched (CNOM). On that model, the State could consider classifying a 28-day Level III.5 residential substance abuse treatment stay as "acute stabilization" and have it covered as a CNOM.